career structure is that the more commonly research becomes incorporated within higher training, so that such experience can be gained with little or no prolongation of senior registrar or equivalent tenure, the more control has to be held over the number of available posts.

Geographical spread of senior registrar training and research is another related issue, and I should hate to think that I had made any suggestion which might lead to a perpetuation of the present disparity.

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Primary care and the small practice

SIR,—The leading article by Dr Robin Hull concerning the white paper on primary care (5 December, p 1436) touches on the problems which could beset small practices with the proposed increase in patient numbers and committed hours that will be needed to qualify for the full basic practice allowance.

If these proposals are implemented small practices which are small by design (because of other commitments, husband and wife units, women doctors, health) or small by circumstance (starting up, in area of heavy competition, location) will be penalised by reduction in income at the same time as being forced to accept a higher commitment. Such practices already receive less proportionally than their colleagues (no group practice allowance and higher expenses with locums), and many of these will become untenable.

Small practices are not commensurate with low standards as is implied in the white paper. Many such practices in this area outshine in service and standards their larger counterparts, some of which hide behind the anonymity of "the health centre." Small practices are an important part of community medical care. Pricing them out will do nothing but harm.

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Acupuncture as an antiemetic

SIR,—Dr W M Weightman and his colleagues (28 November, p 1379) are to be congratulated on the design and execution of their study, which failed to show any beneficial antiemetic effect of acupuncture with their particular anaesthetic technique. Their claim that the findings were contrary to those reported by us[1] is untrue, however, as our anaesthetic technique differed fundamentally from theirs. Using a similar technique (alfentanil-methohexitone, nitrous oxide, oxygen) with electro-acupuncture given during the operation, we likewise failed to find any benefit from acupuncture.[2] In groups of 20 patients undergoing minor gynaecological operations eight in the acupuncture group were sick during the first four hours after operation compared with six in the control group.

We do not know how acupuncture works as an antiemetic but its timing in relation to the use of an opioid appears to be crucial. Given before or with intramuscular nalbuphine premedication it is very effective (our current figures for sickness in the first six hours after operation are 38/56 with no acupuncture compared with 13/56 when acupuncture was used), but given after the opioid becomes "fixed" it is not effective.

There is much we do not know about the mode of action of alternative medicine techniques, but, as with orthodox medicine, like has to be compared with like. Even minor differences between our anaesthetic technique and that of the New Zealand workers can be very important and we must be careful to use the same methods when trying to verify the findings of others.

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1 Dundee JW, Chestnutt WN, Ghaly RG, Lynas AGA. Traditional Chinese acupuncture: a potentially useful antiemetic? *Br Med J* 1986;**393**:583-4.
2 Milligan KR, McKay AC, Dundee JW. Failure of acupuncture to influence postoperative emesis in outpatients. *Ir J Med Sci* (in press).

Promoting better health

SIR,—The proposals in the government's white paper on primary care (5 December, p 1497) suggest a shift in general medical practice from the treatment of the sick and handicapped to preventive medicine.

I suspect that there are many practitioners both fully occupied and fulfilled by their present commitment to the management of illness who are apprehensive about this proposed extension of service. It would appear that much of the present personal interpretation of professional responsibility enjoyed by general practitioners will be replaced by directives from outside agencies, in many cases enhanced by the offer of extra remuneration. This may be attractive for some but it will dismay others who have cherished professional independence.

The new concepts of preventive medicine could have provided an honourable career structure for a limited number of doctors who have both the training and inclination for such work, leaving those who still think general practice means supportive and curative medicine free to continue as before.

What is likely to happen is a competition for time between these equally necessary medical activities to the detriment of both.

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Hyperglycaemia and porphyric attacks

SIR,—The case recently reported by Dr A G Yalouris and Professor S Raptis (14 November, p 1237), although most interesting, contains a conceptual flaw. While there is evidence that a high carbohydrate intake can curtail porphyric attacks there is no proof that this approach also works prophylactically. The four references quoted by the authors in support of their assumption that "a high intake of glucose or carbohydrates offers protection from porphyric attacks" do not contain this evidence.

The difference between the assumed prophylactic and the proved therapeutic effectiveness of carbohydrates for porphyric attacks is not trivial but clinically important. I have seen patients who in the hope of preventing porphyric exacerbations consumed large amounts of carbohydrates, with obesity the only result.

While there is little doubt that starvation can indeed induce a porphyric crisis, carbohydrate loading should be used only early in an attack, quickly to be supplemented by haematin if the symptoms do not abate rapidly. All diabetics should strive for normoglycaemia at all times, even when they have an inducible porphyria.

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The death of Oscar Wilde

SIR,—Dr J B Lyons's letter (12 December, p 1567) on the terminal illness of Oscar Wilde is both timely and judicious. The encylopaedic nature of Professor Ellman's recent biography may lead to uncritical acceptance of his conclusions by reviewers and literary historians.[1] The evidence that Wilde had been infected by syphilis is sketchy and based on gossip rather than any professional facts that have come to light.

Three days before Wilde died a report dated 27 November 1900 and signed by his attending physicians, Dr Paul Claisse and Dr A'Court Tucker, stated clearly that their patient had a meningoencephalitis due to a chronic suppuration of the right ear; there was no mention of any underlying luetic process.

Wilde's symptoms comprised unilateral deafness dating from his imprisonment, fever, and intense headache, which required repeated opiates and local applications of leeches and icepacks. We are not told whether or not the deafness was progressive or whether it was accompanied by otorrhoea. Intractable headache does not suggest syphilis but favours a septic infection. The late Sir Terence Cawthorne was of the firm opinion that Wilde's death was the outcome of an intracranial complication of otitis media.[2,3]

In the terminal picture there was also an obstinate skin irritation, attributed by Wilde—rightly or wrongly—to mussel poisoning. It suddenly cleared up, only to return. The nature of the rash is debatable.

We are often told that Wilde had a medical clearance before his marriage to Constance Lloyd. Up to now no supporting evidence has emerged. His doctor was Dr Charles de Lacy Lacy of Grosvenor Street, Mayfair, but no records appear to have survived his death in 1932.

At present I am writing another paper on this subject. Has any *BMJ* reader further data bearing upon Wilde's medical history?

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1 Ellman R. *Oscar Wilde*. London: Hamish Hamilton, 1987.
2 Cawthorne T. The last illness of Oscar Wilde. *Proc R Soc Med* 1959;**52**:123-7.
3 Critchley M. Oscar Wilde. A medical appreciation. *Med Hist* 1959;**1**:199-201.

Time to start changing the time?

SIR,—Greenwich Mean Time is a standard by which the whole world sets its clocks. Dr J G Avery (19 December, p 1586) contends that this is no longer in harmony with the British times of starting and finishing work and school and supports changing the clocks. Why not change the times: there is no magic, for example, in starting school at 0900.

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Correction

Potassium citrate mixture: soothing but not harmless?

An error occurred in this letter by Dr Roger Gabriel (5 December, p 1487). The values for urinary potassium should have been expressed as mmol/day and not μmol/day.